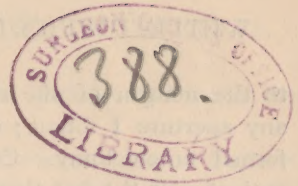


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A NOTE ON TWO CASES ILLUSTRATING SOME MINOR
DIFFICULTIES IN THE DIAGNOSIS OF HERNIAS.

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Case 1. Mrs.——, aged 69 years, was admitted to the Philadelphia Hospital, on the evening of December 16th, 1887, suffering with a painful tumor situated a little external to the middle of Poupart's ligament, on the right side. She had nausea and vomiting, but said she was frequently subject to these symptoms as a result of indigestion. The tumor had been of slow formation, seemed quite mobile, and was not larger than a hickorynut; the skin was red and adherent. There was no distinct impulse on coughing. It was evident that pus had formed in the region of the swelling. During the night after her admission her vomiting ceased, and she had two large formed stools. The following day she was given a few whiffs of ether, and I proceeded to dissect down to the swelling, believing probably that it was but a periadenitis or an enlarged and inflamed lymphatic gland, but recognizing the possibility of error in the history of the case and therefore proceeding carefully. After going through the skin and superficial fascia and opening the deep fascia, there was a free discharge of pus, but at this time, two points attracted my attention. The finger failed to recognize the gland, which usually forms the centre of such a purulent collection, and the pus which was discharged, was filled with bubbles of gas and was of a slightly feculent color. I at once suspected and announced to the class that I was dealing with a case of the so-called Littré Hernia, in which a portion only of the segment of the bowel is involved, the entire lumen of the intestine not being obliterated.

The history of the case seemed, therefore, in this light to be read as follows: Such a portion of the bowel had engaged in but had not passed through the internal abdominal ring becoming fastened there by inflammatory adhesion. Strangulation of a limited portion of its wall had occurred through contraction of lymph-bands. This was followed by minute ulcerations with escape of gases and of microscopical portions of liquid feces into the surrounding connective tissue. By this theory the slow appearance of the swelling, the absence of fecal vomiting, the free movements of the bowels, and the presence of pus were all readily understood. After reaching this conclusion, I might have proceeded to expose the gut by dissecting it away from its adhesions

presented by the author —

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to the margin of the ring, and then freshened and sutured the margins of any aperture I found; or I would have had the alternative of performing a formal enterectomy. Considering, however, the age and feebleness of the patient, and the fact that she was as comfortable in the hospital as she could ever hope to be elsewhere, I determined not to interfere with the barrier which nature had established between the affected portion of the gut and the general peritoneal cavity. I therefore applied simply a compress of antiseptic cotton with a spica bandage and sent her back to the ward. The following day the diagnosis was fully established by the development of a fecal fistula, which from the character of the discharge probably communicated with the ilium. This remained open intermittently for some months, gradually becoming less, and now has entirely healed without further interference, the patient having retained her strength and health uninterruptedly.

The case is full of interest on account chiefly of the deceptive resemblance to suppuration of the inguinal glands, a condition which is usually so easily diagnosed from all forms of hernia that a mistake would be regarded as almost inexcusable. Yet in such a case as this the operator could hardly have been blamed if he had laid the little swelling freely open, knowing it to contain pus and all hernial symptoms having disappeared. Such a procedure would of course have made necessary an immediate operation upon the gut and might not have been attended with so favorable result.

"Littre" hernias are of comparatively rare occurrence, and but few cases have been recorded. In one case, elaborately reported by Schiffer (*Wien. Med. Presse*, December, 1865) the diagnosis of incarcerated crural hernia with extensive serous effusion into the hernial sac was made prior to operation. There was no vomiting and there were thin watery evacuations. At the operation a peritoneal cyst was found running in front of the sac of the hernia, but the latter, together with a portion of the wall of the small intestine which was adherent to it, were opened during the operation. The entire lumen of the gut was not involved. A fecal fistula of course resulted; the patient died of exhaustion shortly afterward. Schiffer concludes that the cyst was formed by a process of local irritation obliterating the original connection with the general peritoneal cavity and thinks that this, together with the tight adhesions between the gut and sac, may have been due to an ill-fitting truss worn by the patient, which he also thinks accounted for the occurrence of the peculiar form of hernia under consideration. He believes that in such cases early operations are markedly indicated.

Zwicke has reported three cases of Littre hernia. In one (*Charite Annalen*, 1882, page 444) the hernial tumor was apparently perfectly reduced, but the patient died the following day asphyxiated while the bowels were being moved after enema. At the autopsy an intestinal loop from the lower portion of the ilium was found reaching into the internal inguinal ring, forming a hernia the size of a cherry; the mesentery was not at all involved and the intestinal wall only through a part of its circumference so that a stream of water could easily be made to pass the constricted portion of the gut. That

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portion was firmly adherent, and its small sac was dark red and was not gangrenous.

In another case (*Ibid*, 1883, page 404) he operated for an apparent inguinal hernia, but found only a hernia of a portion of the intestinal wall about the size of a bean. It was reduced and the sac ligated and excised. The patient died on thirteenth day with general septic peritonitis. In still another (*Ibid*, page 408) the patient had for years worn no truss believing the little tumor to be a swelling of the gland. On the occurrence of symptoms of strangulation herniotomy was performed and a Littre hernia was discovered. This case resulted favorably. In a fourth case (*Ibid*, page 409) a badly fitting truss was believed to be the cause of a similar condition. The gut was reduced, but the patient died on the fourth day in collapse, and the autopsy showed a slough extending nearly around the circumference of the intestine, but with its centre and origin at the point of constriction. Keetly reported (*Medical Times and Gazette*, vol. 11, 1884) a fatal case in which the gut was found narrowed for twelve inches, the greatest narrowing being at the point of strangulation. Other cases have been reported, one by Dr. Nancrede of this city. As a rule the mortality has seemed to be exceptionally great, doubtless from the fact that in these hernias of circumscribed portions of the intestinal walls the interference with the blood supply of the constricted portion is exceptionally complete. Small hernias as a rule are more dangerous than larger ones and for the same reason.

On the night of March 9th, 1888, Mrs.—, aged 68 years, was admitted to the wards of the German Hospital with a tumor situated over the right saphenous opening, about half the size of a child's fist, tense and very tender on pressure and not accompanied by discoloration of the skin. She was apparently in a condition of mild shock, with a cool, moist skin, feeble frequent pulse, and with a countenance expressive of great anxiety and distress. The tumor could scarcely be handled on account of her complaints of severe pain, but no impulse on coughing was discoverable. She was vomiting freely and had had obstinate constipation for two days. She said that the tumor had appeared suddenly forty-eight hours previously, while she was doing some laborious house work, and said it was precisely similar to one which she had had in London some years ago, and which had been reduced by taxis at that time after a long period of trial. It will be observed that the history (which the patient repeatedly insisted upon), as well as the most prominent symptoms, simulated closely those of a strangulated femoral hernia, certainly at least as definitely as in the preceding case the history and symptoms seemed to exclude hernia.

The following morning the patient was etherized, vomiting and constipation having persisted together with all the above symptoms. The moment, however, that her insensibility permitted palpation of the tumor, it was found by deep pressure that it was lobulated and extended down the thigh in the contrary direction from that ordinarily taken by femoral hernias, which tend to curve upwards over the tense edge of the falciform process. The diagnosis of

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lymphadenoma was easily made, although it was recognized that if the history were true there was a bare possibility of the co-existence of an omental hernia containing a small knuckle of gut. I proceeded at once to remove the mass of lymphatic glands, finding no hernia. The patient's symptoms disappeared entirely with the removal of the tumor and were undoubtedly hysterical in their character, though there is no reason to believe her guilty of any intentional deception. She made an uninterrupted recovery from the operation.

These two cases contrast so markedly and present such exceptional peculiarities in relation to the ordinary symptoms of hernia, that they have seemed to me worthy to be placed on record.
